

# PUBLIC HEALTH



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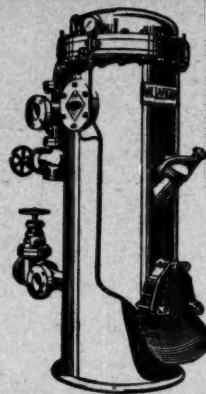
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## EDITORIAL

### A New Session under the Old Name

The main feature of this issue of PUBLIC HEALTH is, of course, the address delivered to a very large meeting at the London School of Hygiene and Tropical Medicine on September 17th by Dr. Charles Metcalfe Brown after his installation as President of the Society of Medical Officers of Health for the session 1953-54. As our new President pointed out, he did not know at the time of preparing his address whether he was to be chief officer of that Society or of "The Society of Preventive Medicine," but his stirring peroration showed that he has the utmost confidence in the future of our Association whether known by the old or a new name.

The vote at the extraordinary meeting, which was so well conducted by the retiring president, Dr. Andrew Topping, showed decisively that the old name of the Society is preferred to the alternative there submitted, although we must presume, from the previous postal vote, that there is a large section of members who would approve a change of name if the right one could be found. In the circumstances, we hope that the present name, which has earned an honourable place and much prestige during the first 97 years of the Society's life, will be acclaimed when the centenary is reached without any further doubts. The attainment of a Royal charter should now be our ambition.

### Care of the Aged: A Scottish Review

A valuable report on "The Ageing Population" by the Standing Medical Advisory Committee of the Scottish Health Services Council has recently been issued. It was prepared by a sub-committee of which Dr. W. G. Clark, our President for 1951-52 and lately Medical Officer of Health for Edinburgh, was chairman, and is obtainable from H.M.S.O. for 6d. Much of what is said of general principles will be already known to most of our readers but some of the points are, we think, of special interest, and one or two are novel.

As a guide to the assessment of need for hostel accommodation the committee suggest that if the old person needs half or more of the working time of a home help then he should be in a hostel. We think that not unreasonable. Generally speaking, it can be said that if the neighbours are unable or unwilling to give some help when the person is so old or infirm that he needs so much domestic assistance, then he is better off in a hostel and economically the State is better off too. Night care by local authority staff would, in such circumstances, have to be considered and that, for long periods, is quite impossible.

The Department of Health for Scotland have suggested a figure of 2.5 hostel places for 100 old people as the present need and we do not think that too high, at any rate in urban areas. It would be interesting to know how the real needs of town and country vary in this respect. We feel, without, it is true, much evidence, that old people in towns probably require paradoxically more hostel accommodation than those in the country.

The committee press for suitable occupation for old people, for some degree of preparation for old age, and for the early recognition and treatment of disease in the elderly before it becomes irremediable. In particular they advocate the provision of facilities whereby periodic overhauls of elderly people can be made and advice given, and quote the comparatively new clinic for this purpose in Rutherglen. It may be remembered that about the end of the last war, Dr. J. V. Walker began such a clinic in Ramsgate though it was not very successful, perhaps because it was too far ahead of its time. A novel suggestion is the creation of a new type of social worker to be styled "social attendants," who would visit old people and give advice and report to medical officers of health and general practitioners on those in need of medical or nursing care. Even here, however, something of the kind has been attempted before, quite apart from the home help service, which might be utilised to some extent in this way. Dr. E. D. Irvine initiated a scheme of this sort in Shipley, Yorks, about 1945,\* but it was applied only to those living in Council bungalows for the aged and therefore only for a small fraction of the aged population.

The committee naturally discuss hospital provision at some length and advocate a figure apart from mental hospital beds of one bed for the aged sick per 1,000 of the total population, about three-fifths of the beds to be beds divided equally between general acute wards and wards providing a geriatric service under a consultant, the remaining two-fifths to be in long-stay annexes. The committee consider that there is much wastage of beds by insufficient care in selection and recommend careful preliminary investigation. The medical officer of health and health visitor are regarded as having an important place in the total scheme of care of the aged and the M.O.H. is reminded, if he needs it, that the general hygiene of all old persons' hostels should be in a special sense within his observation and control.

This is undoubtedly one of the best short accounts of the possibilities and usefulness of public care in this field published within recent years.

\*J. R. San. Inst. (1946.) 66, 4.

## THE NATIONAL PUBLIC HEALTH SERVICE\*

By C. METCALFE BROWN, M.D., D.P.H., Barrister-at-Law  
*Medical Officer of Health and School Medical Officer, City of Manchester.*

The title of this address should really be the National Health Service, but this latter title has been quite erroneously applied to three separate and unlike services—the hospital service, the general practitioner service and the public health service, and it is better to avoid further confusion. The public health service is the only true health service at present—the other two deal almost exclusively with the sick and the injured. Perhaps the title of the National Health Service Act, 1946, was deliberately chosen as a hope rather than a fact in which case the choice was good, but the hope has not yet been fulfilled and the misnomer remains.

It is well, too, to keep in mind and to remind others that Part III of the 1946 Act deals only with one part of the personal health service—the other being the school health service; and that the environmental service, an essential basis of a health service, initiated by our predecessors and continued now by us has been so successful that its value is not fully realised by a community which has no experience of bad sanitary conditions.

The aim of this address is to survey the public health service in the wide sense of the term, to discuss possible improvements and developments and to consider how the three separate services might be modified and ultimately fused to form for the first time a true national health service.

Before doing so, however, I wish to refer to the Croonian Lectures delivered by Sir Allen Daley on "The Place of the Hospital in a National Health Service."<sup>1</sup> Sir Allen has performed a great service in pointing the way to sound and economic progress in the future. At the same time, he has made it difficult for the present president and perhaps for future presidents of this Society to write presidential addresses in that much of what they will wish to consider has been adequately dealt with already in the Croonian Lectures of 1953.

### Local Administration

Regional hospital boards, hospital management committees, boards of governors, executive councils, local health authorities and local authorities each provide office accommodation and equipment, administrative officers and clerical staff. Each also creates committees and sub-committees. An enormous saving in time and money would result from the concentration of the functions of these bodies in the hands of one administrative body for each local administrative area. The multiple fission that has created these boards and councils and their offspring has caused administrative chaos. By means of devices known as integration, co-operation, collaboration, joint consultation and what you will, it is believed by some that chaos will be replaced by cosmos, but without vast changes chaos is more likely to continue.

Centralisation of government has greatly weakened local government with consequent reduced efficiency and a danger of runaway national finance. The obvious remedy can only be achieved by the radical reform and the strengthening of local government. One suitable method would seem to be the creation of about 50 local authorities in the United Kingdom, each administering on average an area of population of about 1,000,000—this figure would need to be adjusted up or down for some areas in order to conform with the limitations of geography, topography, transport routes, commercial needs and the convenience of the people generally but not with traditional local authority boundaries. Each local authority would be an all purpose authority, each would also be a local health authority administering the hospitals and consultant service, the general practitioner service and the public health

service. Administrators would be vastly reduced in number, economic health would return; the national health service would really be achieved.

It would be essential that the local authority should be composed entirely of elected, not nominated, members because only thus can the electorate, who find the money to pay for the service, be in a position to control both policy and finance. The medical profession and other professions and other knowledgeable bodies could and should be represented by co-option to the appropriate local authority committees, the final decisions to rest with the Council composed entirely of elected members.

But it is not my purpose here to attempt to discuss the reform of all branches of local government—I must content myself by pointing out that logical and sound medical administration can only be achieved against a background of general reform. All medical services would be administered by the local health authority and each administrative area could be divided into perhaps five or six divisions with appropriate medical staffs.

But it is necessary to be realistic. Such a scheme would be highly unpopular in many quarters and the political climate at present hardly seems favourable for such radical reform, necessary though it is. But such a scheme or something like it is perhaps nearer than we may think. Sir Allen Daley has quoted a suggestion that hospitals will almost price themselves out of existence—I would go further and suggest that that is precisely what the national medical service is now doing. There must be either a collapse of the service or early and drastic reorganisation—collapse is unthinkable and must not happen.

### The Ministry of Health

The Ministry of Health Act, 1919, in creating a Minister of Health, transferred to him powers which hitherto had been administered by a number of other bodies and on him was laid the duty of co-ordinating all matters affecting the health of the people.

Some of these powers have not yet been transferred; he has been deprived of some of them; in recent years a vast burden of then unforeseen powers has been put upon him. A study of the powers and potential powers of the Minister shows how sound the 1919 Act was. The Ministry of Health supervised the public health services provided and administered by the local authorities. The backward authorities were stimulated to furnish proper services; the authorities whose enthusiasm tended to outrun financial prudence were gently restrained. The valued counsel based on wisdom and accumulated experience of the Ministry was freely sought from its officers and almost invariably accepted and followed. The Minister was in fact a benevolent overseer of the executive functions of the local authorities. It was at its best then—it was advisory and supervisory but not executive.

It is of interest to note that the Ministry of Education functions as the Ministry of Health did formerly. The Ministry of Education has indicated<sup>2</sup> on the subject of ministerial control of the school health service, "The Minister will therefore continue to rely in the main on inspection and the annual returns to satisfy herself on the efficient conduct of the Service, but will expect Authorities to continue freely to consult her Department on points of difficulty or special interest."

Unfortunately, many of the proper functions in the Ministry of Health have been dissipated. The responsibility for housing, which is the greatest public health problem to-day, has been transferred to the Ministry of Housing and Local Government. Central control of duties relating to deprived children is exercised by the Home Office, which deals also with such matters as the efficiency of the police service, the treatment of offenders, legislation on criminal justice, the supervision of the fire service, the control and naturalisation of aliens, explosives, dangerous drugs and intoxicating liquor.

Surely deprived children would be better served if their welfare were the responsibility of the Ministry of Health

\* Presidential Address to the Society of Medical Officers of Health, London, September 17th, 1953.

or the Ministry of Education or both and administered locally by health and education committees whose vast experience of children is unrivalled, and who employ health visitors with all the training and experience requisite for the possession of a health visitor's certificate—a more suitable officer for all kinds of child welfare than those whose basic training has been designed for graduation in imponderables such as public administration or social service.

On the financial side, the creation of a children's officer's department in each major local authority with separate offices and staff, for work that could be at least as well done by health and education departments might well be a fruitful field for the consideration of those concerned with national and local economy. Similarly, if social welfare services can be efficiently conducted by the health departments of some local authorities, why not make this standard practice throughout the country and so eliminate the cost of unnecessary separate departments.

The present government has already started a process of fusing government departments—it is to be hoped that similar unification may be applied to health administration centrally and locally.

The administrative reform of local government and the absorption by large local authorities of the present functions of regional hospital boards, boards of governors and executive councils would remove the large executive functions of the Ministry of Health and allow it to concentrate on its true function. Here again, there would be a great financial saving and the Ministry of Health would be able to provide supervision and advice untrammelled by the hopeless task of attempting to carry out executive action throughout the country by remote control.

### The Hospital and Consultant Service

Changes in administration of hospitals were made inevitable because of the impending financial collapse of many voluntary hospitals and the low standard of hospital accommodation provided by some backward local authorities. Balancing these failures were the efficiently conducted teaching hospitals and the good, well-equipped local hospitals administered by progressive local authorities.

To separate the teaching hospitals from the other hospitals administratively was a mistake—Scotland did well in avoiding this error. To base hospital administrative regions on university towns—and therefore presumably on the medical teaching schools of the universities—was as illogical and unsound as it would be if a large industrial undertaking were to base its executive administration on its apprentice training school. We are fortunate in having in this country consultants of the highest calibre—the result of long years of training, study and experience. To attempt or even to allow senior consultants to spend much of their time in administration and in committee work is a palpable waste of superlative clinical skill. Their advice should receive full consideration in the determination of policy but high clinical success neither denotes nor excludes administrative ability or prescience.

Since the inception of the 1946 Act it is more difficult than formerly to obtain beds for patients. One need go no further than any busy general practitioner to obtain evidence of that. This creates a great deal of unnecessary suffering and distress—the main cause is faulty administration. An example of this type of failure occurred recently in a provincial town in relation to hospital beds. Before the 1946 Act there were occasional shortages which were relieved by temporary expedients applied as soon as the shortage became apparent. Since the 1946 Act there has been a marked scarcity of beds and in consequence a failure to admit patients who should have been admitted. Pressure from the medical profession and others resulted in a systematic survey of the position and as a result of administrative action, without additional buildings or increased staff establishment, the deficiency of beds was greatly reduced within a few months. But it should be noted that it was quite six years before the remedy was applied—a

local authority health committee would have settled the matter in an afternoon, if indeed the difficulties had been allowed to arise at all.

The administration of all hospitals by a small number of large local authorities envisaged earlier would ensure the best use of hospital beds, would guarantee the same full clinical freedom of the profession which they enjoy to-day and would eliminate the colossal waste in relation to present hospital administration. Part of the money saved could be applied to the reduction of the total cost of hospital provision and part to providing still better facilities for the medical and nursing needs of the patients.

### The General Practitioner Service

The administration of this service by the executive councils is in general good but executive councils in cities with large populations operate just as efficiently as those in small towns. It would appear, therefore, that the number of executive councils could be reduced to about one-third of their present number without loss of efficiency and with consequent reduction of expenditure on administration.

The members of executive councils, drawn though they are from five very different types of administrative bodies, work well together and provide a happy example of a harmonious combination of representatives of the profession with representatives of central and local government. If the work of the executive councils did not require to be related to other divisions of medical service, there would appear to be no need to contemplate any administrative change. But the general practitioner service should be a part of a national health service and it was intended to be so. In fact, it suffers greatly in having too little contact with and co-operation from the hospital service and to a less extent too little association with the public health service.

Generally, the general practitioner is not provided with adequate access to the facilities of a hospital—indeed, it is not unusual for him to lose his patient temporarily when the patient enters hospital or attends the out-patients department—even worse, the patient loses his family doctor. The insistence that all beds must be under the control of consultants means that the specialist medical skill and highly expensive apparatus and equipment necessary for the patients occupying some of the hospital beds is provided but not needed by other bed patients who could be well cared for by their family doctors in hospital wards or blocks. The widening of the interest and experience of the general practitioner and the need for the preservation of the continuity of medical care together make a clear case for placing part of the hospital facilities under the direct control of the general practitioner. The present detachment of the three divisions of medical service from each other would make this desirable provision almost impossible—a unified administration of all health services would make it easy administratively.

Since 1946, the general practitioners and public health officers have found that mutual understanding and co-operation has increased and the public health officer is no longer regarded by the general practitioner as a medical rival. This healthy development is in no way retarded by the awareness of both branches of the profession that the greatest adjustment required is not between general practice and the public health service but between both on the one hand and the hospital service on the other.

The few criticisms of the public health department by general practitioners usually arise as a result of the lack of understanding of the duties of public health staff and of the extent to which they facilitate the work of the general practitioners; for example, there is recent evidence that some practitioners still regard the health visitor as suspect and as one who intervenes between the doctor and his patient. Fortunately, an increasing number of general practitioners appreciate that the services of the health visitor are designed to help in an ancillary capacity both him and his patients. Here again, even better and closer relations between these two branches of the profession



could be achieved if the branches sprang from the same administrative tree.

### Short-term Adjustments

The proposals made earlier in this address are by no means new; they have been discussed at length over a period of several years in many quarters and it is unlikely that they will be received enthusiastically by the majority of the medical profession. Nevertheless, the reorganisation of local government and the transfer of the administration of all local medical services to local authorities would be an admirable and lasting solution of the many difficulties that have arisen before and after the 1946 Act.

The principle of a National Health Service was excellent; the application of the principle was too hasty for success; mistakes were inevitable because evolution, not revolution, is the normal method of achieving progress in the practice of medicine. The mode of inauguration of the new service in 1946 was a typical example of the danger envisaged in a different context by the *Observer* newspapers "there is always, of course, when reactions are 'on,' a risk of throwing out the baby with the bath."

Pending reorganisation, institutions for the care of the mentally defective should be returned to the existing local health authorities. This part of the service has broken down and the long list of cases waiting for admission to beds occupied by very long-stay cases is a heartbreaking feature of the mental health service. The division of responsibilities for the mentally defective between the regional hospital board and the local health authority was an administrative error and the sufferers are the mental defectives and their families. We should make haste to put this right.

The tuberculosis service, too, suffers from the same ailment. There are really three parts of this service—domiciliary prevention undertaken by the local authority, clinical supervision in the tuberculosis clinics and the homes, and clinical treatment in sanatoria. By a stroke of the pen, the first and second could be combined profitably under the control of the local health authority—general reorganisation would bring in the third in due course.

In regard to infectious diseases, notifications (except for leprosy) go to the Medical Officer of Health who is also responsible for prevention, but cases of infectious disease can be admitted to and discharged from isolation hospitals without the immediate knowledge of the Medical Officer of Health.

Unification of administration would certainly stop that but meanwhile in the interests of the public health administrative adjustments should be made to obviate the present dangers.

Many other examples of changes which are required immediately could be cited by Medical Officers of Health—they could and should be made forthwith pending major changes.

### Industrial Medicine

A variety of committees have spent in recent years hundreds of hours considering this question—these reports have been published and then quietly put in the file. There has been a strenuous attempt to make industrial medicine a fourth branch of the service; fortunately so far this attempt has failed.

Industrial medicine is not a separate subject—it is but one of the many applications of general medicine and public health. Industrial medicine consists of diagnosis and treatment on the one hand—the job of the family doctor—and on the other hand, prevention of injury and disease—the duty of the public health service. There is a place for full-time medical officers in large industrial undertakings—but relatively few are needed and in any case the experience required by these medical officers is that of a good general practitioner. The few specialists who exist in the field of so-called industrial medicine are very necessary, e.g., the expert on poisons used in industry—but surely he is a specialist in toxicology not a medical officer in industrial medicine. The institution of a system

of industrial medicine separate from the first three branches would but add to the existing disunity and high cost of administration.

### Environmental Medicine

The community, including perhaps ourselves, has tended to accept years of successful progress as evidence that we have subjected our environment to our control and in consequence there has been a tendency to neglect environmental medicine. Mortality, and therefore presumably morbidity, is about 22% higher in the north than in the south in this country and this must be due, in the main, to differences in environment. Housing continues to be a serious problem—so serious that we must keep on saying so and strive in every possible way to achieve faster rehousing. Little progress is made with regard to atmospheric pollution although there have been glimmers of the light of hope in recent years and a more favourable public opinion in relation to preventive measures. The control of food is far short of perfection and our standards of cleanliness are far too low, and in consequence dysentery is rife.

These are but examples of the many important things that need our greater attention in relation to environment.

### The Medical Officer of Health

"The world has cycles in its course, when all that once has been, is acted o'er again." And so it shall be in the case of preventive medicine. It reached low ebb in 1946 but the tide keeps moving towards the flood. There are many signs that preventive medicine is coming into its own again and when it is finally realised that all doctors must practise preventive medicine it will have reached its proper place and so be of maximum service to the community.

In recent years it has been suggested both openly and covertly that the Medical Officer of Health should consider himself fortunate to be alive professionally. The title of Medical Officer of Health may pass away sooner or later but it is certain that a medical officer will always be necessary to devote his whole time to the health of the community; the area of his practice is the area of the local authority and every citizen is on his list. He, on behalf of the community, controls and co-ordinates the public health services; he is the interpreter of the elected representatives of the people to the medical profession; he is the interpreter of the needs of medicine in the service of the people to the local authority. His opportunities of service are increasing daily and I firmly believe they will go on increasing. There is much work to be done by those with a true sense of vocation.

### Our Society

As I write, I know not whether our Society will be of Medical Officers of Health or of Preventive Medicine—I do not greatly care. What I do care about is the future of the Society and I have no doubt whatever that it is bright. I feel strongly that, small though our numbers are as compared with the numbers of our colleagues in other sections of our profession, we shall from now on make rapid progress, given hard work in our chosen sphere and diligence in ascertaining and fearlessness in proclaiming the truth. In matters of practice and policy we should continue to foster our close and friendly relations with the British Medical Association of which most of us are members and to share with them the objects of promoting the medical and allied sciences and of maintaining the honour of the medical profession. But above all we must dedicate ourselves to the service of the people and, in the interests of that service, maintain the independence of our Society.

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## SKIN AFFECTIONS OF THE SCHOOL CHILD\*

By IAN SNEDDON, M.B., M.R.C.P.

Although since the war the incidence of most of the common skin ailments has lessened considerably, partly as a result of better nourishment, better home hygiene and health education and the result of the work of the school health services, some problems such as the ringworm infections are still with us; the epidemic of warts shows no sign of decreasing, impetigo is becoming more troublesome and scabies, after a complete lull, is showing signs of a revival. We cannot, therefore, afford to sit back.

## Scalp Ringworm

There has been a great deal of literature on the subject of scalp ringworm in the last five years, most of it extremely controversial. The study of ringworm seems to generate dogmatism and perhaps irritability in the student. I feel, therefore, that an evaluation of the problem and a reasonable statement of policy regarding ringworm of the scalp would at the time be of value. In order to do this it is necessary to go back to fundamentals and I am going to quote from perhaps the best work done on ringworm since Sabouraud, the work of Kligman (1952). He carried out experimental work in a home for mental defectives. Briefly, he found that infected hair was necessary to start infection. Cultures of the organisms were not effective. A minor degree of trauma such as rubbing of the scalp increased the incidence of infection. Only 60% children could be infected, some having a natural resistance.

After infection, fluorescence with Wood's light took six days to develop and it was necessary to pluck out the hairs to find it, the glowing band could be seen 1 mm. above the hair level. A spreading lesion could thus be detected by finding the fluorescent zone in hairs beyond the patch. This seems a useful practical method.

The experimental ringworm reached its maximum after three months and then remained static. Reinoculation in static cases failed to establish new lesions. The experimental cases cleared spontaneously, but in some the infection lasted over a year. Adults could be infected but their lesions cleared rapidly.

Essentially the findings in *Microsporon canis* infection were the same except that spontaneous recovery occurred earlier. So much for this interesting experimental work. Now for what occurs in the natural disease.

The main age incidence is from 6 to 12 and boys are affected three to four times as frequently as girls. The reason for this is probably the greater ease with which an infected hair can reach the scalp in boys though there may be also a sex difference in susceptibility as there is in other ringworm infections. Some evidence that hair clippers are the means of infection has been obtained but this is not the only explanation.

Clinically, the two infections can be differentiated in most cases.

*M. audouini* infections present with dry, scaly thinned areas in the scalp but increased scurf without broken hairs may be the only sign and in occasional cases no naked eye evidence of infection can be found.

*M. canis* infections more frequently show pustulation and erythema and also lesions on the skin and there may be a history of an infected kitten in the house. The history also tends to be shorter.

Under Wood's light, *M. audouini* infections appear to fluoresce more vividly than *canis* infections. Wood's light is a most necessary part of the equipment in examining cases since only with its use can the full extent of the infection be estimated and the contacts cannot be examined properly without it. Also fluorescent hairs for culture should be picked out during the examination.

I believe that all cases of ringworm should be investigated by culture. It only takes about five to seven days to obtain a diagnosis and the knowledge is most useful in conducting the treatment. If *M. canis* is grown then the probability is that local treatment alone will cure the infection. Speedy cure is likely if the lesion shows a well marked inflammatory reaction. There are, however, a few cases of *canis* infection which clinically resemble *audouini* infection both in their clinical features and in their resistance to local treatment.

If *M. audouini* is grown, then local treatment is less likely to bring about a speedy cure. The probability of cure from local applications varies with the extent of the infection. Kligman (1951) has shown that where a single lesion occurred, 66% could be cured by local applications but where more than a quarter of the scalp is affected, only 30% could be cured.

It also varies with the thoroughness of the treatment rather than with the particular local application used. Kligman again has shown that rubbing in simple carbowax base gave equally good results as using a potent fungicide and many workers have demonstrated that manual epilation and scrubbing in ointments with a toothbrush increase the cure rate.

Now should ringworm cases be excluded from school? I think that until more work has been done on the spread of infection, the sporadic cases should be excluded from school.

It is true as Thomas has said that *canis* infection does not spread from child to child indefinitely, but it is believed that it can spread from four to six passages before it is necessary to return to an animal (Walker, 1950) and this is sufficient spread to be troublesome.

The other difficulty about allowing *canis* cases to go to school is that in localities where both types of *Microsporon* flourish, one will have one rule for the *canis* cases and another for the *audouini* ones. This is not an easy state to administer.

Where there is a large epidemic, then I feel that it may be wiser to try the effect of local applications and leaving the children at school since the cure will depend on altering the immunity of the community. Generally speaking, therefore, I consider that sporadic cases should be isolated until we have further evidence that case-to-case transmission in *canis* infection is not likely.

One thing I would like to stress is search for the undiagnosed cases and this means examination of the whole school where a case has occurred.

If I might therefore summarise the policy:—

(1) Wood's light must be used to diagnose the extent of infection in the individual and the numbers of cases in a group.

(2) Cultures should be done to determine the type of ringworm.

(3) In small epidemics and sporadic infection, children should be excluded from school.

(4) Local treatment should be used for *canis* cases except in a few resistant cases where after 12 weeks there has been no response, x-ray epilation may be necessary.

(5) *M. audouini* cases—in all but the slightest infections x-ray epilation should be used.

(6) In a large epidemic it is probable that local applications and no exclusion from school would be the right policy.

## Impetigo

We come now to the other common scourge, impetigo. After the war impetigo nearly vanished probably as a result of the impact of locally applied penicillin but during the last few years it has increased. Figures of impetigo cases seen in the skin clinic at the Royal Infirmary, Sheffield, are shown in the table overleaf.

Sixty-three of the total number of cases seen in 1951 were investigated bacteriologically. *Staphylococcus pyogenes* was cultured in all and in 48 (77%) the strain was penicillin resistant.

\* Read to Annual General Meeting of the School Health Service Group, June 19th, 1953.

TABLE  
SKIN CASES SEEN AT ROYAL INFIRMARY, SHEFFIELD.

Year	All conditions	Impetigo	Per cent.
1949	4,457	171	3.84
1950	4,682	202	4.31
1951	4,462	294	6.39

In view of these results we began to use chloramphenicol locally and at first it worked just as dramatically as penicillin used to. Very soon, unfortunately, staphylococci resistant to chloramphenicol began to be isolated.

In a study of the bacteriology of 48 cases of impetigo early this year, staphylococci were found in 47, in association with streptococci in 10, and streptococci alone in one. Of the 47 staphylococci 34 (72%) were resistant to penicillin and 11 (23%) were resistant to chloromycetin.

It can be seen, therefore, that the antibiotics applied locally in impetigo have only a limited use unless one can keep introducing new antibiotics and so be one jump ahead of the organisms. The alternative to the antibiotic is to return to more traditional remedies and here I would like to mention a substance which does not appear to be widely known and which is of the greatest use in removing crusts from impetigo. It is far preferable to starch poultices. This is emplastum vaseline and plumbi. It is applied on lint and left on for 24 hours; when it is removed the crusts either come off adherent to the lint or can be removed easily with a swab moistened with liquid paraffin.

After removal of the crusts one can use either the old-fashioned ung. hydrarg. ammon. or lot. cupri sulph. The average case will clear with these. We are at present using in difficult cases aureomycin but this is not freely available. However, judging by previous experience, resistant cases will soon arise and I feel that the antibiotics should, as a matter of policy, be avoided as much as possible though when faced with a rapidly spreading infection, I am afraid I use them.

### Warts

We now come to the question of warts. There seems to be a countrywide epidemic of warts at present and the maximum incidence is in the school child, although many adults are also affected. There is general belief that all forms of wart are caused by the same virus, the differences in appearance varying with the part of the body affected.

Three common varieties of wart are of importance in children. The first, the plane or juvenile wart, which occurs mainly on the face but also on the backs of the hands and on the legs, is of significance because of difficulty in diagnosis. Plane warts on the face being skin coloured and aggregated together simulate very closely a vesicular eruption and can be mistaken for an eczema, even more so in some cases where they give rise to scaling. The fact that they are symptomless, unchanged from day to day and frequently show the Koebner phenomenon appearing in scratch marks, will usually lead to the correct diagnosis.

They are comparatively easy to cure using 5% salicylic acid in paraffin molle as an ointment. Cases which resist this can be treated with freezing or diathermy.

Plantar warts are of significance because they are painful and appear to be more contagious than the other varieties. There is no doubt that trauma to the feet is an important factor since so often it arises after a nail in a shoe has damaged the sole. Recently, I was consulted by a school medical officer about an epidemic of plantar warts in a school where it was the custom for the children to hand on their gym shoes one to the other and it did appear likely that the virus was being conveyed in this way. Barefoot dancing on wooden floors with the possibility of trauma to the feet plus infection may spread plantar warts.

Some plantar warts in children are not painful and the child and parents may be unaware of their presence but because of the risk of infection to others, treatment should be instituted if they are found. In my hands, the most

useful treatment has been the formalin foot bath originally described by Sidney Thomson (1943), and I do not understand why it is not more generally accepted as the first treatment. It works in 80% of cases below the age of puberty though its efficacy falls off after puberty.

The technique consists of immersing the wart and surrounding skin in 5% formalin for 15 minutes daily. In most cases a saucer is a suitable receptacle. After a week, the skin around the wart is dry and "fixed" and the wart has become painless. At this stage I tell the parents to try crumbling away the wart with the blunt edge of a pair of scissors and this allows the formalin to penetrate farther.

In a series I followed up a few years ago, 80% were cured in six weeks. Errors in treatment which give rise to failure are the dilution of the formalin, the application of the formalin on a swab, the use of the same few c.c. of formalin over and over again, and perhaps most important of all, the failure to carry out the treatment at all. The advantages of this method are cheapness, cleanliness and safety.

Should this method fail, then I remove the warts by curettage under local anaesthesia. I freeze the skin with ethyl chloride before putting the anaesthetic needle in. There is in my opinion no need for radiotherapy, which is potentially dangerous. Freezing I have found unreliable and the podophillin and elastoplast techniques are time consuming, messy, and cure no more than formalin.

The ordinary common warts are of significance from a cosmetic point of view and because sometimes they bleed profusely when injured. It is usually the child's parent who is more bothered about them than the child. There is a good chance that the warts will disappear spontaneously and I feel that initially suggestion therapy at any rate in young children is worthy of trial. Many techniques are possible but I give the child something such as ung. hydrarg. ammon. to apply itself with a long rigmarole about applying it. This is far preferable to using caustics, which are, generally speaking, unsatisfactory.

If one is faced eventually with having to take active steps, then I use liquid nitrogen. This is applied on a wooden applicator with a twist of cotton wool on it. Liquid nitrogen can be cheaply and easily obtained; 1s. worth would treat 30 to 40 patients.

The wart is frozen for 10 to 20 seconds and with a little experience the operator can achieve a high cure rate.

### Molluscum Contagiosum

Whilst on the subject of warts, it is worth mentioning *Molluscum contagiosum*, a virus infection conveyed in water and occurring mainly on the trunk of children who attend swimming baths. These can be cured easily by spiking the lesions with a wooden applicator dipped in pure phenol.

I have tried the antibiotics aureomycin and chloromycetin, both internally and externally, for warts and *Molluscum* without success.

### Asthma-Eczema

I should like to turn now to that problem that is always with us—the asthma-eczema child. You all know the type of child with leathery, lichenified skin on the face, neck and flexures, undersized, yet over-intelligent, who is hedged around by restrictions of what he can eat or do by his over-anxious distraught parents, and who is constantly being kept away from school for one reason or another.

During recent years, it has been more and more realised that allergy plays only a very small part in these cases and that far more important is the inherited personality and the environment of these children.

I hope that with a more understanding approach to the problems of eczema in infancy, less of these difficult cases will remain in the school years in the future.

The prognosis of these cases depends entirely on the attitude of the parents. If the mother and father can be persuaded to adopt a more detached attitude to the problem, then the child cannot blackmail them so well and will recover.

Impossible cases are those where the parents are too stupid to understand the problem or where there is an insoluble home situation.

A good example of this was present in a child I saw a few weeks ago. A girl of 12 had suffered from eczema, from one to two years of age and then it had cleared. Her father died when she was three and the mother soon married again and had another child. After the birth of the step-brother the eczema recurred and has been present since. The main factor which keeps it going is the attitude of the step-father, who lavishes all his affection on his own child. The mother is torn between loyalty to her first born and her husband. The only time the eczema has cleared has been when the child has been in hospital and when she stayed for some months with her grandmother.

I feel that this type of case can benefit enormously by going to a residential school. There is a risk that because of homesickness, the eczema and asthma may become worse but this is a risk worth taking. The residential school should not be a special school; it should be possible to fit these children into normal school activities. At the present time, it is a very difficult problem but I am sure it would pay dividends. I would like to draw your attention to a fascinating study of the subject by Richard Harper (1953), who describes his experiences of a family school and its effect on allergic disorders.

The treatment of the eczema child is, however, a subject in which we could spend hours and I have made my main points that, as far as possible, these children should not be treated as invalids but an attempt should be made to find places at residential schools for them.

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### HOUSING PRIORITIES

#### Differential Award of Points on Medical Grounds

By J. H. WEIR, M.D., B.H.Y., D.P.H.,  
 Medical Officer of Health, Royal Borough of Kensington

Faced with the thankless task of attempting to rehouse vast numbers of applicants in a minimal number of houses, those much maligned public servants the Housing Officers may frequently be inclined to regard themselves as lineal descendants of Ishmael. Apart from their unenviable task of having to contend with the vociferous and unsatisfied majority of claimants, they have to cope with the difficulty of deciphering medical calligraphy and of understanding the significance of diagnoses such as "hysterical prolongation of a depersonalisation syndrome." In addition to whatever assistance the Medical Officer of Health may be able to give in translating such esoteric communications, he is frequently required to help in assessing the precise value which should be assigned to various conditions of ill-health so far as claims for priority in rehousing are concerned.

As pointed out in the Third Report of the Housing Management Sub-committee of the Central Housing Advisory Committee, "in all but a very few cases, housing need arises from overcrowding, ill-health, lack of separate home or other unsatisfactory conditions of an applicant's present accommodation."

It must always be a controversial point as to what weight should be given on medical grounds to an unhealthy family and what importance should be attached to a healthy family on other grounds. Similarly, to what extent are we entitled to give consideration to prevention in the case of a healthy family in unhealthy surroundings? And, finally, which is

the greater benefit to the community—to rehouse a healthy family living under bad housing conditions, or to rehouse a family already stricken with disease living under similar conditions? In devising a scheme for the assessment of priorities for rehousing on medical grounds, consideration has to be given to these questions. It cannot be limited to an evaluation of the housing claims of the unhealthy but must also be concerned with the preventive object of ensuring that healthy people are removed from an unhealthy environment.

Incidentally, many applications made on medical grounds are not properly soluble by rehousing. Such adversities as mothers-in-law, noisy neighbours, anxiety neuroses, diabetes, or remediable housing or insanitary defects frequently could and often should be remedied by other means. In this connection it is doubtful to what extent rehousing benefits those suffering from neuroses or psychoses. In many cases improvement, if any, has been very transitory and sooner or later further symptoms have been attributed to influences in the new accommodation and a demand for another change of environment has been made.

Many attempts to solve these problems have been made; most local authorities have adopted a system of pointing, many leaving the assessment of medical priorities to the Medical Officer of Health. Whether the Medical Officer of Health, Housing Officer or some other officer undertakes this task, it remains fraught with pitfalls. It is solved in many ways as, for example, by one of our more colourful personalities—a colleague now enjoying a well-earned retirement—who, during the war, was presented with the invidious task of rehousing hundreds of bombed-out families in the two and a half pre-fabs then available. Asked whether he ever rehoused anybody, he gave a characteristic reply with the familiar Machiavellian grin, "No, brother, but I write them the most beautiful letters!"

In a more practical endeavour to deal with this question many systems have been devised. One system divides the points into two groups—"Basic" points for factors directly affecting housing needs, i.e., overcrowding, ill-health, lack of separate home and the condition of the present accommodation, and "Balancing" points which are given for such factors as war service and length of time on the waiting list, and are only awarded when it is necessary to choose between applicants with an equal number of basic points. Some authorities divide applications on medical grounds into three grades—highly recommended, recommended and not recommended. Others award points strictly based on medical grounds, e.g., 10 for tuberculosis, and so on.

Attempts to reach a differential assessment of the points to be awarded for a given complaint are governed by personal opinion and the resultant awards vary widely according to the particular circumstances and to the personal reactions of the assessor. So far as can be ascertained, no scheme has been described for calculating the number of points to be awarded for ill-health in such a way that the claims of the sick and the healthy in relation to their environment are equitably reflected.

In such a scheme, it is necessary to decide the number of points which shall be awarded on general grounds, such as length of time on the waiting list, the number on grounds of unavoidable separation, shared accommodation, overcrowding, lack of amenities, etc., and the number for unsatisfactory housing conditions. Then to cope with the necessity for allowing greater priority to the unhealthy for prejudicial circumstances, additional points have to be awarded on medical grounds, taking into consideration the aggravating effects of the aforementioned factors, and such additional factors as lack of privacy, noise, congregation of incompatibles, multiple occupation, inadequate or inconveniently situated facilities, which may be referred to as "inconveniences." Allowance must also be made for other factors such as infection risk, multiple illnesses, etc. The aim is to ensure that people with few "Balancing" points can get early rehousing by an award of "Basic" points if medical conditions warrant this, and that healthy people living in unhealthy conditions are rehoused as a



preventive measure. Each case must be dealt with on its merits, *i.e.*, in relation to others on the waiting list, which translated into practical politics necessitates devising some fair means of reducing the problem to an arithmetical basis.

This is a somewhat complicated problem and where medical reasons for rehousing have been adduced, it becomes necessary to equate the patient's illness and disability with his existing housing, with such alternative accommodation as may be possible, with the risk to others (especially home contacts) and with the claims of others on the housing list.

In Kensington there is a waiting list of approximately 5,000 families, a large number housed in unsatisfactory tenements, lacking amenities and in a bad state of repair. The local points system takes cognisance of these considerations and primarily gives preference to bad housing conditions in such a way that healthy families obtain preventive rehousing and unhealthy ones obtain part preventive and part curative benefits. The system is concerned mainly with awards for bad housing conditions, the only award for other reasons (what have been described as "Balancing" points) being 10 points after five years on the waiting list and a further two points for each subsequent year. No award is given for such items as number of children, place of employment, nature of occupation or residence in a particular district, ward or parish.

The practical application of the differential award of basic points is as follows. Initially, points are awarded by the Chief Housing Officer on an arbitrarily determined basis for general items (all of which incidentally have a bearing on health), such as unavoidable separation, overcrowding, bedroom deficiency, shared accommodation (living rooms, kitchens, water supply, water closets) and lack of facilities (cooker or sink in the living room).

The scale adopted is similar to that mentioned in Appendix 3 (page 28) of the Third Report of the Housing Management Sub-committee of the Central Housing Advisory Committee. In this respect the entitlements of the healthy and the diseased are made on an equal basis of assessment. In addition, the Council have decided to allot a certain number of points for award on the recommendation of the Medical Officer of Health for reasons of bad housing, ill-health, or tuberculosis. He may also make a recommendation for the award of additional points on discretionary grounds.

In cases where claims for rehousing are made on medical grounds, or on grounds of substandard accommodation, the Chief Housing Officer transmits the family particulars and medical certificates to the Medical Officer of Health for scrutiny and assessment.

In each case it is necessary to obtain an accurate assessment of the housing conditions. For this purpose a sanitary inspector visits the premises and ascertains the accommodation occupied, the number, ages and sex of the occupants, details of the living accommodation and sleeping arrangements and the presence of remediable or irreparable sanitary or repair defects. He also enquires regarding such "inconveniences" as multiple occupation, shared accommodation, lack of privacy, congregation of incompartibles, stairs, noise, inadequate washing, heating, cooking or food storage facilities.

The resultant information is entered on the front of the form shown as Appendix to this article. In cases where there are unsatisfactory living conditions—irreparable disrepair or sanitary defects, lack of amenities or existence of inconveniences—the question is asked "Is the disrepair, sanitary or other defect irreparable by procedure under the Public Health Act or the Housing Acts?" An affirmative reply qualifies for an award of up to a stated number of points depending on the nature of defect existing. These are entered on the back of the form under the heading "substandard accommodation."

In cases where, in addition to unsatisfactory living conditions, ill-health is adduced as a reason for rehousing, it is essential to have accurate information as to the precise condition and resultant disability from which the patient

is suffering before any assessment can be made. Vague certificates are useless; for example, "heart disease" may be accompanied by complete incapacity or it may cause no disability whatsoever. "Tuberculosis" may mean phthisis or an accidentally discovered asymptomatic primary infection. "Neurosis" may mean anything—or nothing. In cases where the diagnosis is not sufficiently clear, a standard letter is sent to the medical practitioner enquiring the precise condition from which the patient is suffering, the nature and extent of the disability resulting and the particular aspect of the housing conditions which the doctor considers is having an adverse effect on health. With this and the previous information, an assessment of the number of points to be awarded is made on the back of the form by considering the answers to the following questions:—

1. Is the disability arising from the illness of an acute, chronic or recurrent nature? Acute illness by itself seldom qualifies for a points award.

2. Are the present housing circumstances prejudicial to the patient to an extent greater than in the case of a healthy individual? A negative reply rules out an award on medical grounds.

3. Would rehousing in the type of accommodation likely to be available and within the resources of this applicant benefit the condition? A negative reply rules out an award on medical grounds. An affirmative answer to this and the previous question qualifies for a 25% award of the points.

4. Is there overcrowding? An affirmative reply qualifies for a 25% award additional to that awarded by the Chief Housing Officer to all applicants on grounds of overcrowding.

5. Is there infection risk? If so, an additional 25% is added.

6. Is there irreparable sanitary or housing defect? An additional 25% is added.

(These percentages are entirely empirical and could, of course, be varied according to personal opinion or in the light of experience.)

The percentages obtained are then totalled and applied to the stipulated number of points in the case of tuberculous disease, and to two-fifths of this number in other medical conditions. Over and above this award, discretionary points are given for medical reasons in cases which are particularly urgent or deserving on medical grounds; for example, where a grave public health risk obtains, or where there are multiple medical conditions in the same patient, more than one case of illness in the household, illness in one patient and an expected addition to the family. Additionally, the number of points awarded for substandard accommodation may be more liberally assessed on grounds of defects or inconvenience which may have a bearing on the complainant, *e.g.*, stairs and cripples; shared washing or sanitary accommodation and tuberculosis; damp basements and rheumatism; inconveniently situated water supply or sanitary accommodation and heart disease. The points are then totalled and the Chief Housing Officer advised of the award recommended on medical grounds.

As the number of points allocated by the Council for each item taken into consideration have not been made public, it is not possible to give the actual numbers involved. Suffice it to say that, with certain modifications, they are similar to those mentioned in the sample points scheme given in Appendix 3 of the Third Report of the Housing Management Sub-committee of the Central Housing Advisory Committee.

Using the figures given therein as a basis for an example, the pointing of the following imaginary case would be as shown in Table I. (Additional points for tuberculosis to a possible maximum of 15 have been brought into this computation.)

A seven unit family—father, mother, daughters aged 20, 19, 17, sons aged 14 and 12 years. Two daughters notified cases of infectious pulmonary tuberculosis; one daughter notified as primary tuberculous infection.

Occupying three basement rooms, badly lit, inadequately ventilated and affected with rising dampness. Sharing water closet accommodation with another family; no bathroom. Permitted number, five.

Overcrowding, bedroom insufficiency, infection risk, irremediable sanitary defects.

TABLE I

Points awarded by the Chief Housing Officer for		Points
1. Statutory overcrowding: two over permitted number (two points for each $\frac{1}{2}$ unit) ...	...	8
2. Bedroom deficiency: two deficient (10 points for each) ...	...	20
3. Shared accommodation: water closet ...	...	2
Total ...	...	30

Points awarded by the Medical Officer of Health for

1. Substandard accommodation: basement; defective light and ventilation; dampness; no bath; shared w.c.; overcrowding; bedroom insufficiency ...	...	10
2. Prejudicial environment: as above. Rehousing likely to benefit? ...	25%	100% of
Overcrowding: two over permitted number ...	25%	10 for
Infection risk: two open cases of tuberculosis ...	25%	ill-health
Irremediable sanitary defects: as under 1 above ...	25%	15 for tuberculosis
3. Discretionary award: three cases of tuberculous infection (two sputum positive). Conditions prejudicial to recovery. Grave public health risk to four contacts. Premises do not comply with Underground Room Regulations and require closure when vacated ...	...	10
Total ...	...	45
Grand total ...	...	75

While it is probably impossible to devise a perfect points scheme for rehousing priorities, at least the system described is an attempt to equate five variables in such a way that points are awarded on a sliding scale which shows a certain amount of discrimination towards various medical conditions and yet equitably reflects the housing merits of the healthy and the diseased. Practical experience gained in operating the system for the past two years, during which 392 cases have been dealt with, has suggested that it works reasonably well.

Table II shows the percentage of the maximum points available under the combined headings of substandard accommodation, ill-health including tuberculosis and discretionary award, which have been recommended in respect of these cases.

TABLE II

Percentage of points		Cases
No award ...	...	85
0% ...	...	58
10% ...	...	91
20% ...	...	61
30% ...	...	50
40% ...	...	17
50% ...	...	18
60% ...	...	8
70% and over ...	...	4
Total ...	...	392

Thus, in 392 cases claiming rehousing on grounds of ill-health or substandard accommodation, 21.6% received no award; 53.5% up to 30%; 21.6% between 30% and 60%; and 3% over 60% of the total points awarded on these grounds.

Broadly speaking, if all other circumstances are equal, a family with medical grounds for rehousing gains to a greater or lesser degree on a healthy family and it is possible for cases in which strong medical reasons obtain, to be pointed higher than those with superior claims so far as length of time on the waiting list and bad housing circumstances are concerned.

## APPENDIX

Page 1

# ROYAL BOROUGH OF KENSINGTON PUBLIC HEALTH DEPARTMENT

## Allocation of Housing Points for Substandard accommodation/ill-health/tuberculosis

Name. 1. ....  
Age .....  
2. ....  
Age .....  
3. ....  
Age .....

Address .....

Accommodation and general impression of dwelling: .....

### Number and ages of family

	Over 10	Under 10	Total units
Males:			
Females:			

P.N. .... Actual .....

Statutory overcrowding: YES/NO

Situation:

1. Cooking facilities	Exclusive/Shared
2. Water supply	Exclusive/Shared
3. Bath	Exclusive/Shared
4. W.C. (number of persons)	Exclusive/Shared

Sanitary defects:

Remediable .....

Action taken: .....

Irremediable .....

Inconveniences: .....

Main detriment to health adduced by applicant: .....

Comments: .....

Date submitted to Medical Officer of Health: .....

Sanitary Inspector

Page 2

1. Disease	Medical points:	
Disability	Environment	25%
2. Disease	Overcrowding	25%
Disability	Infection risk	25%
3. Disease	Irremediable sanitary defects	25%
Disability		

(concluded overleaf)

Duration ..... Acute/Recurrent/Chronic  
 Environmental adversities in relation to :  
     Present housing  
     Alternative housing  
 Infection risk .....  
 Additional medical considerations .....

Substandard accommodation	...	...	...	...
Ill-health	...	...	...	...
Tuberculosis	...	...	...	...
Discretionary	...	...	...	...
		Total	...	...

Date .....  
 Initials of Medical Officer of Health .....

### OBITUARY

IN MEMORIAM : DR. RENÉ SAND : 1877-1953

René Sand was born at Ixelles, Belgium, on January 30th, 1877. He was a Vice-President of the First World Conference on Medical Education which met in London on August 22nd last and had agreed to preside over the section dealing with Preventive and Social Medicine. The opening address which he had prepared appears in the *British Medical Journal* of August 29th. The opening day was overcast by the news that he could not attend as he had had to enter a hospital for an operation. He died the following day, August 23rd, and the conference, at a plenary session, paused to pay tribute to his memory.

He was a most remarkable and lovable man : tall, with penetrating blue eyes, but, sometimes, in later years, with a far-away look in them. His command of language, in many tongues, was superb. He had superabundant energy and vitality and attended a conference in India a few months ago when he was 75 years old. Though idealistic in all his endeavours, he was, nevertheless, essentially a man of affairs and he got things done. When he could not get all that he wanted, he accepted gracefully as much as was possible.

Though the concept of "Social Medicine" goes back to 1848, it was Sand who acted as its present-day proponent. He was a prolific writer but his life work is all incorporated in "The Advance to Social Medicine" published in 1952 and which is a translation of the original work in French published in 1948.

He graduated in medicine in Brussels in 1900 and was trained as a pathologist. So long ago as 1912 he founded the Belgian Social Medicine Association. But he was a citizen of the world rather than of one country and few were better known outside their own country. In 1921 he was elected Secretary-General of the League of Red Cross Societies. In 1929 he founded the International Hospitals Association of which he was the first President. This became the International Hospital Federation and he presided over its conference, held in London last May, with his usual vigour, clarity and humour. In 1946 he presided over a technical preparatory committee of U.N.O. to study international organisation in the health field out of which grew the W.H.O. In 1950 he was appointed Chairman of the W.H.O. Expert Committee on Professional and Technical Education. An honour which touched him deeply, as he was a modest and humble man, was the award, in 1951, by W.H.O. of the Léon Bernard Foundation Prize for his contributions to international health.

In his own country he was Secretary-General of the Ministry of Health in 1937 and was responsible for the establishment of the Institute of Hygiene and Social Medicine in Brussels in 1939. But it was not until 1945 that his university founded a chair of social medicine. Sand was its first occupant and he retained this office until last year. He was an honorary member of the Belgian Royal Academy of Medicine, a Grand Officer of the Order of Leopold and of the Order "de la Couronne." In 1951 he received an honorary L.L.D. from Glasgow University.

An activity in which he will be greatly missed is the investigation into medico-social work in England and in France under the joint auspices of W.H.O. and the Rockefeller Foundation. Sand had been appointed to overlook the enquiry and to co-ordinate the findings of the two teams whose work has just been completed. Another of his projects, not yet come to fruition, was to found an International Association of Health Officers but he planted a seed which may yet bring forth fruit.

The world is richer by the life and work of René Sand. Those who had the privilege of his friendship will ever retain the memory

of his buoyant personality, of his serious discussions relieved by shafts of wit and boyish fun, and, always, of the stream of ideas which flowed from his brilliant mind. They were ideas which gave inspiration to his hearers and made clear that here was the evangelist, the missionary, the zealot.

ALLEN DALEY.

GEORGE SINGLETON PARKINSON, C.B.E., D.S.O., Brig. R.A.M.C. (ret.), M.R.C.S., L.R.C.P., D.P.H.

The death on August 18th of Brig. G. S. Parkinson, briefly reported in our last issue, takes away a man who was known and held in affectionate regard by many public health colleagues in the civilian and armed services and by generations of D.P.H. students at the London School of Hygiene and Tropical Medicine. He was born in 1880, a member of an Irish Protestant family, and educated at Bath College, whence he went off to the South African war as a cavalry trooper. Thereafter he qualified in medicine at Bristol in 1906 and was commissioned in the R.A.M.C. in 1908. During service in the first world war as D.A.D.H. and A.D.M.S., 1st Army, he befriended and guided many temporary R.A.M.C. officers ; he was thrice mentioned in dispatches and gained the D.S.O. in 1918. His next post was the military one of M.O.H., Gibraltar, whence he became Assistant Professor of Hygiene at the R.A.M. College, Millbank. When he retired from the R.A.M.C., with the rank of Lieut.-Colonel, in 1928 he joined the staff of the Society of Medical Officers of Health as assistant to one of his former temporary R.A.M.C. colleagues in France, G. S. (now Sir George) Elliston, and thus became known to many members of the public health service. The story of his work with Prof. W. W. (now Sir Wilson) Jameson at the London School is told by the latter below. On Sir Wilson's appointment to the Ministry of Health, Parkinson, who had returned to the R.A.M.C. as A.D.H. Eastern Command in 1939, came back to the School as Acting Dean and Director of the Public Health Department from 1940 to 1943, a period of which he was particularly proud. Then he returned to war service in North Africa and Italy where he was director of the Allied Military Government's Public Health Commission and gained a United States medal for his control of the typhus outbreak in Naples. He received the C.B.E. in 1945. After his final retirement, with the rank of Brigadier, he took an active part in the work of the Foot Health Educational Bureau as chairman of its advisory committee from its inception. In 1950 and 1951 he spent several months in Greece advising on the reorganisation of the Athens School of Hygiene, for which he received the thanks of the Greek Government. He was a Fellow of the Society from 1922, and was a foundation member and honorary secretary between the wars of the Navy, Army and Air Force Hygiene Officers' (now Services) Group, of which he was also the first President when it was re-formed after the last war.

Sir Wilson Jameson has kindly sent us the following tribute to Brig. Parkinson :—

"I first met Brig. Parkinson (Parky to all of us) in 1928 when he was working with George Elliston in the Society's office. He had been strongly recommended as a person likely to be very helpful in building up the Department of Public Health Administration in the new School of Hygiene and Tropical Medicine to the staff of which I had just been appointed. I did not know then how popular he had been with the various Sanitary Sections under his command in the first world war, but I soon realised what a loyal and knowledgeable colleague I had been lucky enough to secure. Henry Clay, a stalwart from the Marylebone Health Department, and Miss K. M. Shaw, chief clerk in the Chesterfield Health Department, decided to throw in their lot with us, so the four of us, with Crowden in Applied Physiology, began to plan the first whole-time University Department of Public Health in England. We soon settled down into a very happy little team and, though we differed from one another in all sorts of ways, we had this in common that, no matter at what personal inconvenience, the School and its interests had to come first.

"The first one of the team to go has been Parky. He was the oldest of us but who would have thought a week or two ago that he would die with such shocking suddenness—not, I am sure, that he would have had it otherwise.

"He and Miss Shaw were the people to whom the students of the School went with all their problems and what endless pains they took to help. Parky had a fund of common sense and a great sense of humour. He was really interested in people and filled with a desire to help them. The works staff and the porters in the School worshipped him as indeed did the servants of all the institutions to which he belonged. He was a great letter-writer, filling pages in his small handwriting with his comments on matters in general and on his own and his correspondent's affairs in particular. He never forgot the little courtesies of life.



It was always he who remembered to write the letter of thanks to persons who had helped the department in some way or other and who was ready at all times to meet and to entertain the countless visitors who came to the School. It is easy to understand why he had friends all over the world, people he had helped at some time or just people who had found in him good companionship. No matter how humble the person, Parky was just as interested in him as though he had been of more obvious consequence—that was the secret of his popularity.

"He enjoyed the simple pleasures of life—a dinner with a friend, a day at Lord's, a week or two's fishing—but above all his garden at Epsom with his trees and his birds.

"He will be sadly missed."

EDWARD A. FITZGERALD, B.D.S. (IRELAND)

We are indebted to the Hon. Secretary of the Northern Ireland Branch for the following tribute:—

"It was with deep regret that members of the Northern Ireland Branch of the Society heard of the death of its esteemed member Edward A. Fitzgerald, on July 2nd, 1953, at the early age of 50. Ned, as he was best known to his associates, had gone to Co. Donegal for a short holiday prior to attending the annual British Dental Association Conference at Buxton when he was taken suddenly ill and passed away within a few hours.

"Possessed of a charming and friendly disposition, Edward Fitzgerald had many friends, and one had only to be in his company a short time to realise that he was one of 'Nature's gentlemen.' Formerly practising as a dental surgeon in Armagh City, he later joined the School Dental Service and was appointed County Dental Officer to Armagh County Health Committee some four years ago. As a member of various Dental Committees his wise counsel and guidance were eagerly sought, but his chief interest lay in the Public Dental Officers' Group (Northern Ireland Branch) of which he was Chairman.

"Edward Fitzgerald also took a keen interest in medical affairs and was a member of the Northern Ireland Branch, being its Treasurer for the past three years.

"He is survived by his wife and three sons, to whom the Northern Ireland Branch extends its profound sympathy."

## BOOK REVIEW

**Pulmonary Tuberculosis.** By WALTER PAGEL, M.D., F. A. H. SIMMONDS, M.D., D.P.H., and NORMAN MACDONALD, M.B., M.R.C.P. (EDIN.). Third edition. (Pp. 728. Price 84s.) London: Geoffrey Cumberlege, Oxford University Press, 1953.

This third edition of a well-known work is a worthy tribute to the memory of two of the original authors. The second edition published in 1948 was the last major work to appear before the advent of modern chemotherapy, which has produced great changes in both the medical and surgical management of pulmonary tuberculosis. Comparison of this volume with its predecessor is therefore an excellent way in which to assess the progress made in the specialty during the intervening five years. By skilful re-writing the authors have managed to incorporate their additional material without increasing the size of the book.

A text-book of this kind has the advantage of being an integrated work rather than a collection of monographs. The proper study of tuberculosis requires that it should be regarded both as a disease of individuals and an affliction of the community. The clinician must know not only the details of the specialty he practises but must also be aware of the impact of the disease on all aspects of his patients' lives. The best public health administrator is he who remembers that a wood is made up of individual trees, and who makes his plans for the betterment of the community with due regard for the individuals who compose it.

It is impossible to read this book and to fail to be impressed by the increasing exactitude of diagnosis and stricter criteria for healing of tuberculosis which have come about as the result of improved techniques in bacteriology and radiography, and a better knowledge of the pathology of the disease. The unsatisfactory group of "T.B. minus" cases is diminishing as better methods of isolating the bacilli become available and non-tuberculous chest conditions are more accurately recognised. The high standard now required before healing is accepted should do much to reduce the relapses which have been a depressingly common experience.

The first two chapters of the first part describe the tubercle bacillus and the pathology of the disease. The chapter on resistance to tuberculosis is a clear exposition of modern views on this

difficult subject. The remainder of Part I is occupied by an account of the natural evolution of tuberculosis in man, and is an indispensable foundation on which to build any scheme of either individual or communal management. Parts II and III are good straightforward accounts of the diagnosis and prognosis of the disease. Part IV describes the clinical treatment. It begins with an exposition of the aims of treatment and continues with an account of the uses of chemotherapy, its scope and limitations. Collapse therapy and resection are preceded by a most valuable section on the physio-pathology of the tuberculous lung, and the general consideration of the aims of these forms of treatment, before going on to describe each in detail. The arrangement of this part of the book is very good, and is one of the outstanding achievements of this edition. The importance is stressed of bronchoscopic assessment of the state of the bronchial tree before any form of collapse therapy is undertaken. The development of chemotherapy and surgical procedures, together with a better appreciation of the causes of its complications, has brought pneumothorax treatment under review, and it is interesting to compare the views expressed by the authors with those of Foster Carter and his colleagues in the Brompton Hospital Reports for 1952.

The other kinds of collapse therapy are described; the section includes a good up-to-date evaluation of the various resection procedures, and ends with accounts of the management of such conditions as tuberculous empyema and other matters not previously described.

Part V concerns the epidemiology and prevention of tuberculosis. The place of tuberculin surveys, radiological surveys, and *post-mortem* surveys in estimating the amount of tuberculous infection, the value of notification figures and mortality records in estimating the amount of tuberculous disease in the community are carefully considered. There is adequate mention of the various factors which influence the spread of the disease and the steps which can be taken to counteract them, always provided that no major catastrophe overtakes us. There is a full account of B.C.G. vaccination and a briefer mention of the vole bacillus.

The publishers are to be congratulated on the attractive way in which the book has been produced. There is a comprehensive bibliography at the end of each chapter and a good general index.

**British Standards Yearbook, 1953.** (Pp. 487. Price 12s. 6d.) London: British Standards Institution, 2 Park Street, London, W.1.

The British Standards Institution performs a useful service in laying down physical requirements that not only tend to prevent multiple variations of a single fitting by different manufacturers but also ensure that apparatus conforming to B.S.I. specifications is of good quality and free from avoidable defects. Inspection of the Yearbook for 1953 reveals plenty of interest for the medical officer of health. Among the 1,966 items for which standards have been prepared, building, lighting, heating, drainage, and clothing are all included. In addition, reference is made to special publications dealing with codes of practice, such as the provision of ventilation, cesspools, sanitary appliances, mechanical refrigeration, and precautions against fire. All of these concern apparatus and functions that are subject to physical standardisation and are clearly within the province of the Institution. There are, however, other functions, such as the bacteriological examination of dairy products and the standardisation of disinfectants, that depend upon biological methods. The principles governing biological standardisation are quite different from those governing physical standardisation, and it seems a pity that the Institution should trespass on a field which in this country is looked after by other bodies and internationally by the World Health Organisation.

**Health Services Conference.**—The conference to be convened by the Institute of Public Administration at Church House, Westminster, from October 28th to 30th, will have as general theme "Making the Most of Present Resources." Mr. Henry Lesser, C.B.E., will be the chairman and amongst the opening speakers at sessions will be Mr. L. Farrer-Brown, secretary, Nuffield Foundation, on the financial considerations; Professor A. Leslie Banks and Dr. H. Kenneth Cowan on domiciliary and out-patient services and Sir Fred Messer, chairman, Central Health Services Council, on medical planning in the regions. Dr. J. M. Gibson will speak in the session on the Whitley system. Applications should be addressed to the Director, Institute of Public Administration, Haldane House, 76a, New Cavendish Street, London, W.1.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH

### NOTICES

#### THE ANNUAL DINNER

The Annual Dinner of the Society of Medical Officers of Health is to be held at the Piccadilly Hotel on Thursday, October 22nd, at 6.45 for 7.15 p.m. The President, Dr. C. Metcalfe Brown, will be in the chair and the principal guest will be Miss Florence Horsbrugh, M.P., the Minister of Education. Tickets can be obtained from the Administrative Officer. Price 27s. 6d. (Remittances should accompany applications.) Early applications are requested.

#### FEVER GROUP

The Fever Group of the Society of Medical Officers of Health are joining with the epidemiological and other sections of the Royal Society of Medicine to organise a discussion on the treatment of bulbar poliomyelitis on Friday, October 16th, at 4.30 p.m., at the house of the R.S.M., 1, Wimpole Street, London, W.1. Prof. Lassen and Dr. Ipsen, of Copenhagen, will open the meeting by speaking about the poliomyelitis outbreak in Denmark. On Saturday morning, October 17th, at 10.30 a.m., members of the Group will visit the poliomyelitis unit at the Western Hospital, Seagrave Road, Fulham, S.W.6. Those who intend to be present at the Western Hospital should inform the hon. secretary of the Group, Dr. J. C. MacEntee, Grove Hospital, Tooting, S.W.17, as soon as possible.

#### SCHOOL HEALTH SERVICE GROUP

An ordinary meeting of the Group will be held in Rooms 7 and 8, Friends' House, Euston Road, London, N.W.1, on Friday, October 16th, 1953, at 4.30 p.m. Dr. Mary L. Gilchrist will deliver her address as President of the Group for 1953-54 on "The Changing Face of School Medicine."

#### DENTAL OFFICERS' GROUP

A general meeting of the Group will be held in the Old Library, B.M.A. House, Tavistock Square, London, W.C.1, on Saturday, October 24th, 1953, at 2.30 p.m., with the President (Mr. Sydney B. Newton, L.D.S.) in the chair. Miss Jean R. Forrest, L.D.S., of the Ministry of Health, who was a member of the United Kingdom Mission to North America, will open a discussion on "The Fluoridation of Water Supplies."

All members of the Society who have an interest in this subject are invited to attend and join in the discussion.

### REPORTS

#### EAST ANGLIAN BRANCH

*President* (1952-53): Dr. K. J. Grant, O.B.E. (M.O.H., Great Yarmouth C.B.).

*Hon. Secretary* [ Dr. A. J. Rae (Deputy C.M.O., West Suffolk).

A meeting of the Branch was held at the Grange Restaurant and Country Club, Brome, on Saturday, June 13th, 1953, at 3 p.m. The President was in the chair and 12 members were present.

Members noted with pleasure the recent award of the O.B.E. to the President, Dr. K. J. Grant, for services rendered during the floods earlier this year, and directed that their appreciation of this well-won honour should be recorded in the minutes of the meeting.

The Hon. Secretary reported on a letter dated April 15th, 1953, that had been received from the Administrative Officer of the Society concerning the proposed change of name of the Society.

Dr. K. F. Alford, Deputy County Medical Officer, Norfolk, was unanimously elected President for the coming session and the other officers and representatives were re-elected.

The meeting then considered Dr. A. E. Brown's report on the Branch's proposals for research, and after considerable discussion it was decided to call for volunteers to serve on a committee to go further into the matter and bring, if possible, some project or projects before the next meeting of the Branch. The committee was then elected with Dr. P. A. Tyser as its Secretary.

## HOME COUNTIES BRANCH

*President*: Dr. J. Maddison (M.O.H., Twickenham M.B., and Area M.O., Middlesex).

*Hon. Secretary*: Dr. F. G. Brown (M.O.H., Wanstead and Woodford M.B., and Area M.O., Essex).

On May 15th, 1953, the Branch made a most agreeable expedition to Somerset at the invitation of Cow & Gate. Members were conveyed in the greatest possible comfort to Wincanton and were entertained to luncheon at the White Horse Hotel by Col. Gates, grandson of the founder, who spoke in a most interesting way of the origin and expansion of Cow & Gate.

During the afternoon members toured the factory, which is one of a number in the milk-producing counties of England and Wales.

The methods of inspecting farms and of sampling milk from individual herds were first described. Members then watched the churns arriving and being weighed, emptied, steam-sterilised and dried. The milk was followed in its passage through cooling, standardising and cleaning operations to the hot roller machines. Here it solidifies and is collected looking like sheets of tissue paper. The sifting and packing which follow were watched with interest, and the rapidity and economy of the packers' movements were particularly admired. Finally, the painstaking and comprehensive methods of laboratory control were demonstrated.

After tea the interest of members was turned from the 20th to the 18th century by a visit to the charming village of Stourton and to the gardens of the Stourhead estate. This is acknowledged to be one of the finest examples of landscape designing in England, if not in the whole of Europe. The gardens were given to the National Trust in 1947 by Sir Henry Hoare, having been carefully preserved by his family since their creation between 1741 and 1750.

The water from several springs forming the source of the river Stour has been brought underground to a grotto and made to pour round the reclining figure of a nymph into a vast artificial lake. From the shores of the lake the ground rises to display an exquisite collection of rhododendrons, azaleas and conifers. Each new prospect has some embellishment in the form of a graceful classical temple, an elegant stone bridge or an early Gothic revival garden house; everywhere the eye is charmed and soothed.

It is probable that nothing like Stourhead will ever be created again and that it will stand unrivalled as one of the great aesthetic achievements of the 18th century.

It was heartening to reflect on the lessening of the hazards to infant life since that time, however, and the tour of the factory during the afternoon had served as a reminder of the great efforts made in this direction in the present century.

This was a most delightful day which will be remembered with gratitude.

#### MIDLAND BRANCH

*President*: Dr. H. M. Cohen (P.S.M.O., Birmingham C.B.).  
*Acting Hon. Secretary*: Dr. Jean Mackintosh (Admin. M.O.H. for M. & C.W., Birmingham C.B.).

The Annual Meeting of the Branch was held at the Kynoch Works of the Imperial Chemical Industries, Ltd., on Thursday, July 16th, 1953, at 2.30 p.m.

The President was in the chair, and 32 members attended.

#### Election of Officers and Council

The following officers and members of the Council were elected for the year 1953-54:—

*President*.—Dr. J. M. Mackintosh.

*President-Elect*.—Dr. J. W. Pickup.

*Vice-Presidents*.—Drs. G. Ramage, W. R. Martine, T. M. Clayton, C. Starkie and H. M. Cohen.

*Elected Members of Council*.—Drs. J. E. Geddes, H. Paul, S. W. Savage, C. Cookson, Matthew Burn, J. F. Galloway and G. M. Fleming.

*Hon. Treasurer*.—Dr. A. J. B. Griffin.

*Hon. Secretary*.—Dr. W. R. Martine.

*Hon. Auditors*.—Drs. F. L. Ker and E. L. M. Millar.

*Representatives on the Council of the Society*.—Drs. W. R. Martine (ex officio) and T. M. Clayton.

*Representative on Tuberculosis Group*.—Dr. J. E. Geddes.

*Representative on Midland Tuberculosis Society*.—Dr. T. M. Clayton.

*Representative from Midland Tuberculosis Society on the Council of the Midland Branch*.—Dr. Gordon Evans.

*Representative on City of Birmingham Public Health Advisory Committee*.—Dr. W. R. Martine.

*Representative on West Midlands Special Residential Schools Standing Committee.*—Drs. J. W. Pickup, H. M. Cohen and T. M. Clayton.

The nominations for representation on the Council from the Midland Branch of the British Medical Association had not been received at the time of the meeting.

*Life Membership.*—It was proposed by Dr. Cohen and seconded by Dr. Savage that Dr. W. Taylor, who recently retired from the post of Medical Officer of Health for Shropshire, should be nominated for life membership of the Society.

Following the Annual Meeting the members and their friends toured the factory, visiting first the strip mill, as an example of the heavy industry carried on there, and secondly the department which made lightning fasteners.

Thereafter tea was kindly provided at the canteen and this was followed by an inspection of the medical unit and of the kitchens.

Dr. Cohen expressed the thanks of the members and friends for the very excellent arrangements which were made by Mr. Boon, Dr. Marr and Dr. Duncan.

#### YORKSHIRE BRANCH

*President (1952-3):* Dr. J. Wood-Wilson (Dep. C.M.O.H., West Riding).

*Hon. Secretary:* Dr. H. L. Settle (M.O.H., Doncaster C.B.).

A business meeting of the Branch was held on June 26th, 1953, at the Civic Hall, Leeds.

The following officers were elected for the 1953-54 session:—

*President.*—Dr. W. G. Evans.

*Vice-Presidents.*—Drs. J. Wood-Wilson and C. B. Crane.

*Hon. Secretary.*—Dr. H. L. Settle.

*Members of Branch Council.*—Drs. E. C. Benn, C. W. Dixon, W. M. Douglas, Fraser, J. M. Gibson, J. Lyons, G. A. W. Neill, M. C. Taylor and C. G. K. Thompson.

*Representatives on the British Medical Association Branch Council.*—Drs. W. G. Evans, C. W. Dixon, J. M. Gibson and G. A. W. Neill.

*Members of the Branch Council to serve on the Society.*—The President and Hon. Secretary.

*Representative on the Tuberculosis Group Committee.*—Drs. C. W. Dixon and J. Wood-Wilson.

*Hon. Auditors.*—Drs. C. W. Dixon and D. D. Payne.

The Branch then proceeded to discuss a number of matters of general interest raised by members.

Consideration was also given to the proposed new by-laws for the Branch and to a report by a Special Sub-committee which was established to consider problems encountered by Medical Officers of Health in connection with their responsibilities in the control of infectious diseases.

#### "Q" Fever in England

An ordinary meeting of the Branch was held on July 24th at the Department of Preventive Medicine and Public Health, Leeds University, when Dr. H. T. Findlay, Director, Public Health Laboratory, Wakefield, gave a paper entitled "Outbreaks of 'Q' Fever in England." Dr. Findlay first gave a brief review of Rickettsial diseases in man and then dealt with the discovery of "Q" fever in 1937 in Australia. Outbreaks which occurred in Greece, Italy and the Balkan countries in 1946 were also mentioned. The first report of the disease in Great Britain was in 1949 when certain cases of primary atypical pneumonia were found to be suffering from "Q" fever. The main interest in these cases was that three of the patients had never been out of England. During this same year Rickettsial antibodies were demonstrated for the first time in the United Kingdom in raw milk. *Rickettsia burneti*, the organism responsible for "Q" fever, was described and the speaker then briefly dealt with the clinical features of the disease. Particular stress was laid on the highly infectious nature of the disease which can be acquired by either inhalation or ingestion of the causative organism. Dr. Findlay gave details of outbreaks which had occurred in this country and concluded his paper with reference to the results of the special survey which has been made regarding the incidence of Rickettsial antibodies in milk from farms in Great Britain.

A lively discussion then followed in which many members took part, thereby testifying to the interest which Dr. Findlay's paper had aroused. A vote of thanks to the lecturer was proposed by Dr. G. A. W. Neill, M.O.H., Barnsley.



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### SCHOOL HEALTH SERVICE GROUP

*President* (1952-3): Dr. C. Leonard Williams (formerly M.O.H., Barking M.B.).

*Hon. Secretary*: Dr. A. A. E. Newth (Sen. S.M.O. and S.M.O., Derbyshire).

An ordinary meeting of the Group was held at the London School of Hygiene and Tropical Medicine on Friday, March 20th, 1953, at 4.30 p.m. The President was in the chair and 33 members were present.

*Election of New Members.*—The following Fellows of the Society were unanimously elected as members of the Group: Drs. Alison M. Brummitt, Joan I. Buchanan, Ann B. Clark, Hartley Davies, D. G. Evans, F. W. Ford, Frank W. W. Fox, Andrew P. Gorrie, Patricia F. M. B. Gould, Leo Hahn, Diane J. Haiste, F. A. Heimann, Stella G. A. Henriques, Norman A. Jevons, R. E. Jones, Kazimierz Kolaczek, Stuart Lindsay, Margaret G. Martin, Helen M. Mitchell, Rose Moss, Stanley A. O'Hagan, Irene W. Simpson, Gilbert Tattersall and Eleanor M. Whitehead.

*Honorary Secretary's Report.*—The Hon. Secretary reported that the Council of the Group had met that morning and had considered further the draft S.H.S. and Handicapped Pupils Regulations, representation on the Council of the Society, the use of Secker's combs for nits, the rate of working at school M.I.s, the Adoption of Children, and a draft circular of the Ministry of Education on Children with Defective Hearing. They had heard with interest that Dr. Kershaw was among those nominated for the Presidency of the Society and expressed a wish that their representatives should give him their support.

### Research in the School Health Service

Dr. E. R. Bransby, Ministry of Health, then spoke on "Some Reflections on Research in the School Health Service." He said that the approach of the S.H.S. had been empirical but a great deal of the work could be classed as research. Acknowledging that research costs time and money, he thought that it had not been sufficiently encouraged by school medical officers. Statistical techniques need not be too technical. He thought that the school health service did not get sufficient credit from other bodies such as the Medical Research Council. He gave instances of investigations that had proved of great value such as the Cambridge investigation on the dental condition of entrants and Dr. Henderson's survey of epileptics. A great deal of money was being spent on orthodontics, but we did not really know what orthodontic changes occurred naturally. Why were some children chronic "bad doers"? Why did accidents occur in schools, and when and how? How was it that some children in a family showed signs of malnutrition while others did not? He suggested that the service might enquire into its own organisation. Were its methods satisfactory or not? How was it that some thought that routine investigations were of value while others thought that they were not? In proposing a vote of thanks Dr. Cohen recalled that at one time the Chief Medical Officer devoted part of his report—"The Health of the School Child"—to investigations by school medical officers and suggested that this might be resumed.

### Annual General Meeting

The annual general meeting of the Group was held at the London School of Hygiene and Tropical Medicine on Friday, June 19th, 1953, at 4.30 p.m. The President was in the chair and over 30 members were present.

After the minutes of the last annual general meeting held on June 20th, 1952, had been approved and signed, the following Fellows of the Society were unanimously elected as members of the Group: Drs. Marjorie Braine, Dorothy J. Ball, Agnes D. Donaldson, Ian B. Millar, William T. Orton, and Ruth R. Stackley.

*Officers and Council for 1953-54.*—The following elections were unanimous:—

*Officers.* President, Dr. Mary Gilchrist. Past-Presidents, Drs. C. L. Williams and A. Morrison. Hon. Treasurer, Dr. H. M. Cohen. Hon. Secretary, Dr. A. A. E. Newth. Hon. Assistant Secretary, Dr. C. W. Anderson. Representatives on Council of the Society, Drs. Anderson, Cohen and Newth. Hon. auditors, Drs. V. H. Atkinson and E. D. Irvine.

*Council.* Drs. V. H. Atkinson, J. E. Cheesman, R. W. Eldridge, J. Ferguson, J. A. Fraser, C. H. Gibson, P. Henderson, G. H. Hogben, E. D. Irvine, E. M. Jenkins, J. D. Kershaw, A. R. C. Margetts, J. N. Matthews, J. B. S. Morgan, W. J. Pierce, G. D. Pirrie, G. S. Robertson, A. Smallwood, J. W. Starkey, Vera C. Eitch and Gladys F. Wilkinson.

*Report of the Honorary Secretary.* The Hon. Secretary reported that since the last annual general meeting there had been three ordinary meetings, viz., October 17th, 1952, when Dr. Williams gave his Presidential Address, "Eureka"; on January 16th, 1953, Dr. Mary Sheridan, of the Home Office, speaking on the work of the Home Office for children deprived in their own homes; and on March 20th, 1953, when Dr. E. R. Bransby spoke on "Some Reflections on Research in the S.H.S." On November 21st, 1952, a very successful joint meeting was held with the Association Medical Officers of Schools Association under the chairmanship of Dr. Underwood, when the Control of Infectious Diseases in Schools was discussed. The Council of the Group had met on four occasions and had dealt with a variety of questions of importance, including dental treatment of children, arrangements for evacuation, the undesirability of Forms 4 R.T.C. being sent to lay principles of colleges, chiropodists in the school health service, the convalescent treatment of school children, the use of Secker's combs, children with defective hearing, the use of opticians for the routine testing of vision in schools, the adoption of children and the critical tone of certain articles in the B.M.A. Very recently they had discussed again the question of suitable accommodation in schools for medical inspection, the cleanliness of milk bottles and the usefulness of periodic weighing and measuring of children. A very successful refresher course had been held in September.

The Honorary Treasurer presented his report on the finances of the Group.

Dr. Ian Sneddon, M.R.C.P., then read a most interesting paper on "Skin Affections of the School Child," illustrated by lantern slides. It provoked a valuable discussion, in which a large number of those present joined. He was warmly thanked by Dr. Gordon and a lady member. (This paper is published on pages 5-7 of this issue of PUBLIC HEALTH.)

### OFFICIAL NOTICES

#### Gloucestershire County Council

##### APPOINTMENT OF COUNTY DENTAL OFFICERS

Applications are invited for registered Dental Surgeons. Salary in accordance with the Dental Whitley Council (Local Authorities), £800 per annum rising by £50 increments to a maximum of £1,250. The Council will determine the commencing salary in accordance with the candidate's experience. Travelling and subsistence allowances will be paid according to the Council's scale.

The appointment will be subject to the provisions of the National Health Service (Superannuation) Regulations (1947) and the successful candidate must pass a medical examination.

Forms of application, with particulars of the duties and conditions of appointment, may be obtained from the County Medical Officer of Health, Berkeley House, Berkeley Street, Gloucester. Applications should be returned within 14 days of this advertisement.

GUY H. DAVIS,

Clerk of the County Council.

Shire Hall,

Gloucester.

September 24th, 1953.

#### New South Wales Department of Public Health, Australia

##### MEDICAL OFFICER OF HEALTH

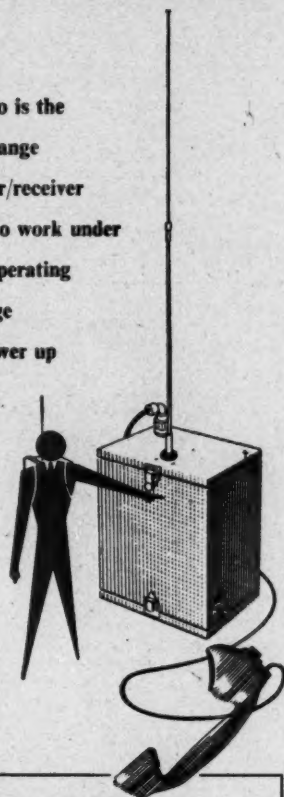
Salary £A.1,762 annually. The duties of the position entail the supervision and co-ordination of public health activities within the Richmond-Tweed Health District. Headquarters located at Lismore, N.S.W., where residence is available at reasonable rental. Applicants should possess the Diploma of Public Health or similar qualifications. Previous experience in the field of Public Health is desirable. Appointee will be eligible, subject to medical examination, to contribute to the New South Wales Superannuation Fund, which will provide an annual pension of up to £1,014 (A). The first-class shipping fare to Sydney of the appointee and his family will be paid. Six copies of applications (together with six copies of testimonials and other supporting documents) should reach the Agent General for New South Wales, 56/57 Strand, London, W.C.2, by OCTOBER 19th, 1953. No special forms of application are available.

## MARCONI

### mobile radio for the

## HEALTH AUTHORITIES

Marconi mobile radio is the general name for a range of V.H.F. transmitter/receiver equipment designed to work under the most strenuous operating conditions. The range offers a choice of power up to 12W and a wide selection of frequencies to meet all operating requirements.



## MARCONI

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## Weaning Food

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General view of the Serum Concentration Laboratory,  
Wellcome Research Laboratories, Beckenham, England

## CONCENTRATION

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